

**Department of Mental Health, Mental Retardation and Substance Abuse Services**

**ENROLLMENT REQUEST**

☐ Check if placing on Statewide Waiting List

**Check type of Waiver:**

☐

**MR WAIVER**

☐

**DAY SUPPORT WAIVER**

Coordinating CSB:

Provider #:

Date of Request

Social Security Number:

Date Service First Needed: **(Waitlist Only)**

Individual's Name:

FIRST

M.I.

LAST

Birthdate: (mo/day/year)

**Race** (for data purposes):

**Medicaid Number:**

**Male :**

**Female:**

- ☐ African American
- ☐ Asian
- ☐ Caucasian
- ☐ Hispanic
- ☐ Native American
- ☐ Other (specify):

☐
☐

**ICF/MR Level of Functioning**

Date Completed: \_\_\_\_\_

**Current Living Situation:**

- ☐ Health Status
- ☐ Communication
- ☐ Task Learning Skills
- ☐ Personal/Self Care

- ☐ Mobility
- ☐ Behavior
- ☐ Community Living

- ☐ Living in the community, at risk of institutionalization
- ☐ Resident of state Training Center
- ☐ Resident of state MH Hospital
- ☐ Applicant to state or community ICF/MR
- ☐ Resident of community ICF/MR
- ☐ Resident of Nursing Facility

**Diagnostic Eligibility:**

Name of evaluator: \_\_\_\_\_

License/Credentials/Title: \_\_\_\_\_

Date psychological evaluation completed

☐ Confirms diagnosis of mental retardation, as defined by AAMR; documentation in record addresses:

- ☐ Intellectual functioning
- ☐ Adaptive functioning
- ☐ Age of onset

Date standardized developmental evaluation completed, under 6 yrs. of age **for MR Waiver**

☐ Confirms "developmental risk" **[NOT APPLICABLE FOR DAY SUPPORT WAIVER]**

**Comments:**

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The individual or parent/legal guardian has been given the choice between institutional care and MR Community/Day Support Waiver services, has signed the "Documentation of Recipient Choice" form, and has selected MR or DS Waiver. With the submission of this form, I certify that the above information is accurate, complete and maintained in the individual's record.

Signature of CSB Representative/Case Manager \_\_\_\_\_

Date \_\_\_\_\_

Phone \_\_\_\_\_

Signature of MR Director \_\_\_\_\_

Date \_\_\_\_\_

PROJECTED Start Date \_\_\_\_\_

**This form must be submitted with the Recipient Choice Form (unless already submitted for Waiting List).**

This individual has been screened and approved to receive MR/DS Waiver services and is waiting to receive MR/DS Waiver Medicaid eligibility determination.

Signature of OMR Representative \_\_\_\_\_

Date \_\_\_\_\_

Approved Start Date \_\_\_\_\_